NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Indicators

Report for Fourth Quarter SFY 2006-2007

April 1 – June 30, 2007

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Quality
NC DMH/DD/SAS

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Statewide Progress in SFY 2006-2007

Services to Persons in Need

- Mental health consumers receiving federal or state funded services in their communities increased one percentage point for adults and 4% for children over the past state fiscal year.
- In the past four quarters, developmental disability consumers receiving federal or state funded services in their communities increased by 2% for adults and 5% for children.
- Services to adult and child substance abuse consumers decreased 2% and 1%, respectively, over the past four quarters.

Timely Initiation and Engagement in Service

- Statewide, initiation of mental health consumers into care has increased minimally (2%) over the state fiscal year, while engagement of these consumers into care climbed steadily from 19% in the first quarter to 24% in the fourth quarter (a 5% increase).
- Developmental disability consumers also increased in initiation over the state fiscal year, climbing from 56% in the first quarter to 66% in the third quarter and then dropping to 60% in the fourth quarter. A similar pattern occurred with engaging these consumers over the state fiscal year. After climbing 13% between the first and third quarters (from 41% to 54%), a drop occurred in the fourth quarter (to 48%).
- Progress was made in initiation and engagement of substance abuse consumers into care over the state fiscal year. Initiation increased from 58% in the first quarter to 64% in the fourth quarter and engagement increased from 40% to 46% in the same time frame.

Effective Use of State Psychiatric Hospitals

- Statewide, there was a small drop in the number of consumers receiving short term care (1-7 days) in state psychiatric hospitals over the past year (2%).

Timely Follow-Up after Inpatient Care

- There has been relatively little change in follow-up care for consumers discharged from ADATCs (a 2% increase for consumers seen in 1 to 7 days) or state psychiatric hospitals (a 1% increase for consumers seen in 1 to 7 days) statewide over the past year.

Consumer Choice of Service Providers

- Over the past state fiscal year, there has been a slight increase in mental health and substance abuse consumers reporting receiving a choice of providers (from 70% in the first quarter to 72% in the fourth quarter).

Use of Evidence-Based Service Models and Best Practices

- Statewide, the number of LME catchment areas that had providers identifies to provide all six of the services based on best practice models grew by 1 (from 13 to 14) and the number of catchment areas in which providers were actually billing for all six services grew from 1 LME to 4 LMEs.

Consumer/Family Involvement in System (CFAC Attendance)

- Attendance at CFAC meetings increased across the state by 2% over the state fiscal year.

Effective Management of Information

- Data submission of consumer admission information has maintained at a very high level throughout the year, ranging between 93% and 95% statewide over the last four quarters.
- Data submission of consumer outcome information increased by 3% from the first to the fourth quarter of SFY 2006-2007.

Introduction

Effective management of community systems is essential for the success of North Carolina's efforts to transform its mental health/developmental disabilities/substance abuse service (MH/DD/SAS) system. Tracking the status and progress of community systems provides a means for the public and General Assembly to hold the Division of MH/DD/SAS and the Local Management Entities (LMEs) accountable for progress toward the goals of the system reform. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

The following pages constitute the fourth report in the SFY 2006-2007 series on local progress indicators.[1] These indicators measure each local system's progress in three areas:

- Service Delivery
- Service Quality
- System Management

Within each of these areas, the Division has selected indicators to gauge problems and progress on reform goals. Each area covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state government staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they provide critical highlights that can guide analysis by the public, the General Assembly, and local and state managers into more detailed issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators were chosen to reflect:

- accepted standards of care,
- fair and reliable measures, and
- readily available data sources.

The following pages present graphs showing the progress of each LME on the nine selected indicators for the most recent time period available. Measures relying on service claims data are delayed by 90 to 180 days to allow time for claims to be processed. The source information below each graph provides details on the data systems and time periods used. Also presented are highlights of progress on measures from the second quarter to the fourth quarter (as many measures changed after the first quarter report).

For the progress area Service Quality, LMEs are grouped according to their population density. The resulting categories – Urban, Mixed, and Rural – group LMEs that face similar challenges (e.g. transportation, number in need of intensive services).[2]

[1] This report fulfills the requirements of S.L. 2006-142 (HB 2077) that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2000-2006, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] The data used to group LMEs into categories is available in Appendix B.

Formulas for calculating each of the indicators as well as tables showing the statistics for each LME on all nine indicators are available in a separate document, the *Appendices for MH/DD/SAS Community Systems Progress Indicators.*[3] Both are available on the Division website at:

http://www.ncdhhs.gov/mhddsas/statspublications/reports

The information in this report complements the Quarterly DHHS-LME Performance Contract Reports, which evaluate each LME's compliance with 30 contractual items. *Indicator 4: Timely Follow-up Care after Inpatient Care* replaces the measure previously used in the Performance Contract Reports. The data for *Indicator 9: Effective Management of Information* appears in both reports.

In SFY 2007-2008 the Division will redesign the current Community Systems Progress Indicators report and the Quarterly DHHS-LME Performance Contract reports. This change is intended to reflect the system's increasing focus on improving service access, availability, appropriateness, quality and effectiveness, while continuing to track adherence to the fundamental elements of good system management.

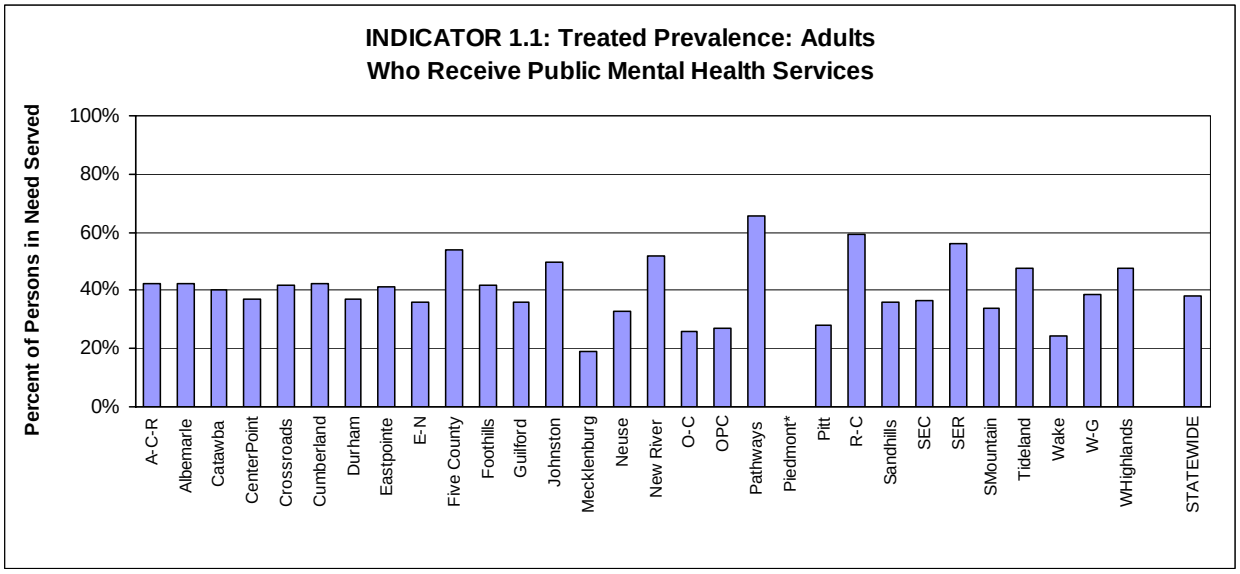
[3] A list of counties that make up each LME is available in the Report Appendix.

Service Delivery

Indicator 1: Services to Persons in Need

1.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. April 1, 2006 - March 31, 2007; N=334,736 adults in need

Almost 55 out of every 1,000 adults (5.40%) in North Carolina experience a severe or severe and persistent mental illness (SMI or SPMI) in any given year.[4] Statewide, 126,980 adults (38% of those in need of services) received federal or state funded MH services through our community service system from April 2006 through March 2007.[5] The rate of adults who were served varied among LMEs from a low of 19% (Mecklenburg) to a high of 66% (Pathways).

Highlights: A total of nine LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 5% (Mecklenburg with the greatest change).

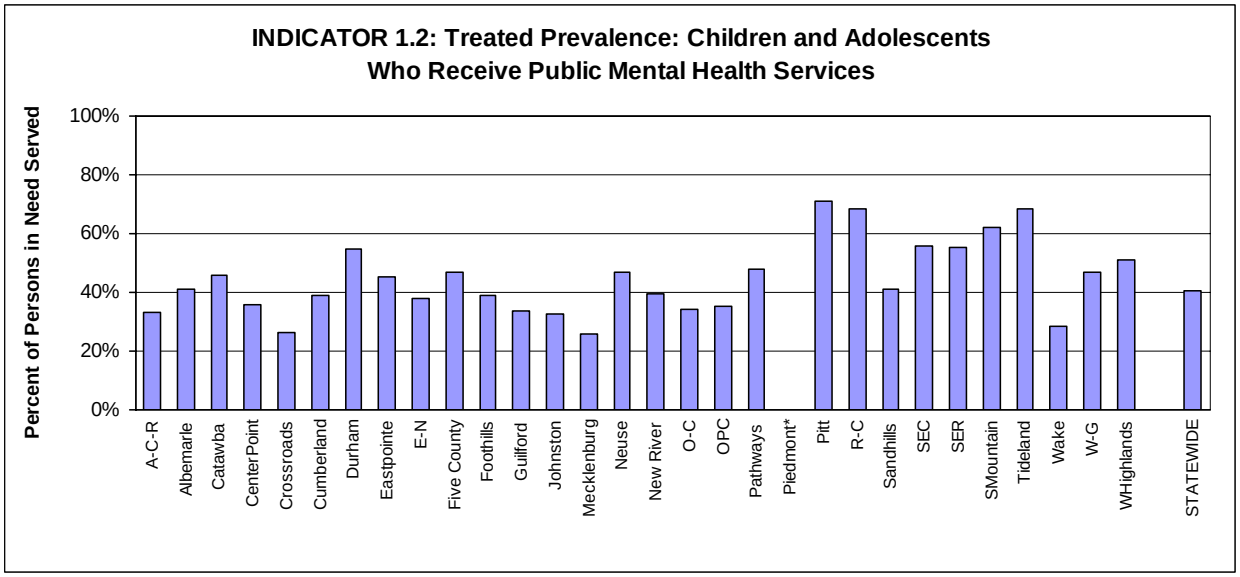
** Data on service claims for Piedmont are not available for this report.*

[4] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2005, Midpoint of range between lower and upper limits of estimate. Prepared by NRI/SDICC for CMHS: August 29, 2006. Estimates adjusted to North Carolina population.

[5] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds.

Indicator 1: Services to Persons in Need
1.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. April 1, 2006 - March 31, 2007; N=196,447 children and adolescents in need

In North Carolina, 120 out of every 1,000 children and adolescents (12.00%) experience severe emotional disturbances (SED) in any given year.[6] Statewide, 79,139 children and adolescents (40% of those in need of services) received federal or state funded MH services through our community service system from April 2006 through March 2007.[7] The rate of those served varied from a low of 26% (Crossroads and Mecklenburg) to a high of 71% (Pitt).

Highlights: A total of 24 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 17% (Pitt with the greatest change).

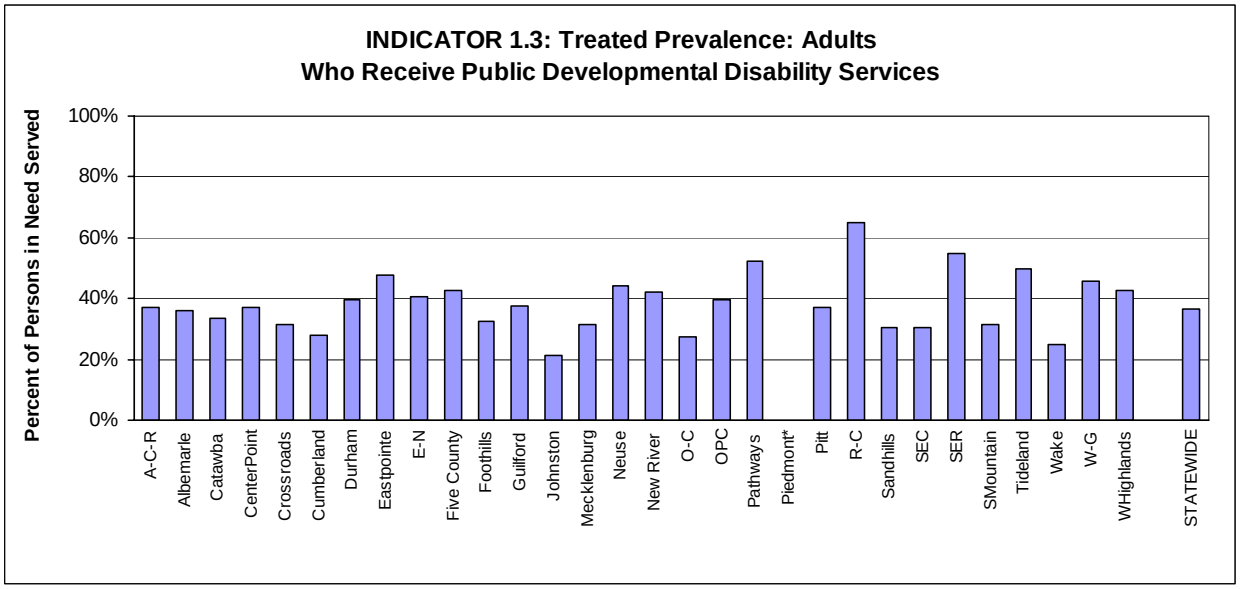
** Data on service claims for Piedmont are not available for this report.*

[6] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2005, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 29, 2006. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist for younger children. Estimates adjusted to North Carolina population.

[7] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2.

Indicator 1: Services to Persons in Need
1.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. April 1, 2006 - March 31, 2007; N=48,971 adults in need

Approximately eight out of every 1,000 adults (0.79%) in North Carolina have a developmental disability that requires supportive services.[8] Statewide, 17,813 adults (36% of those in need of services) received federal or state funded DD services through our community service system from April 2006 through March 2007.[9] The rate of adults who were served varied among LMEs from a low of 21% (Johnston) to a high of 65% (Roanoke-Chowan).

Highlights: A total of 17 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 6% (Mecklenburg with the greatest change).

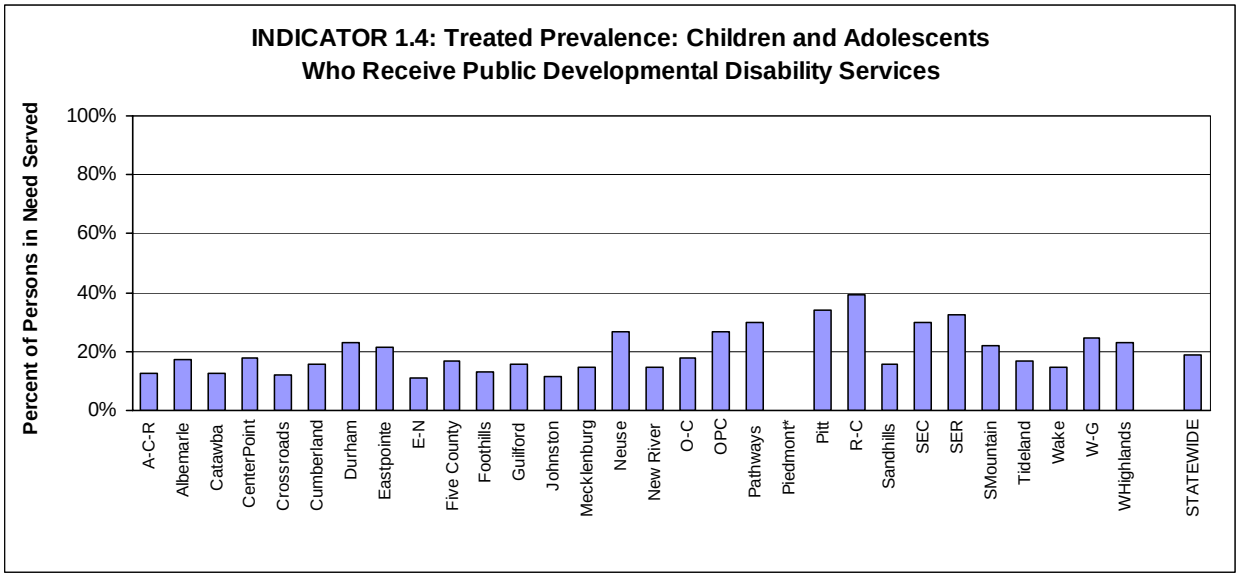
** Data on service claims for Piedmont are not available for this report.*

[8] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Estimates adjusted to North Carolina population.

[9] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 1: Services to Persons in Need
1.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. April 1, 2006 - March 31, 2007; N=52,526 children and adolescents in need

Approximately thirty-two out of every 1,000 children and adolescents (3.21%) in North Carolina have a developmental disability that requires supportive services.[10] Statewide, 9,886 children and adolescents (19% of those in need of services) received federal or state funded DD services through our community service system from April 2006 through March 2007.[11] [12] The rate of those who were served varied among LMEs from a low of 11% (Edgecombe-Nash) to a high of 39% (Roanoke-Chowan).

Highlights: A total of 15 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 3% (Southeastern Center with the greatest change).

** Data on service claims for Piedmont are not available for this report.*

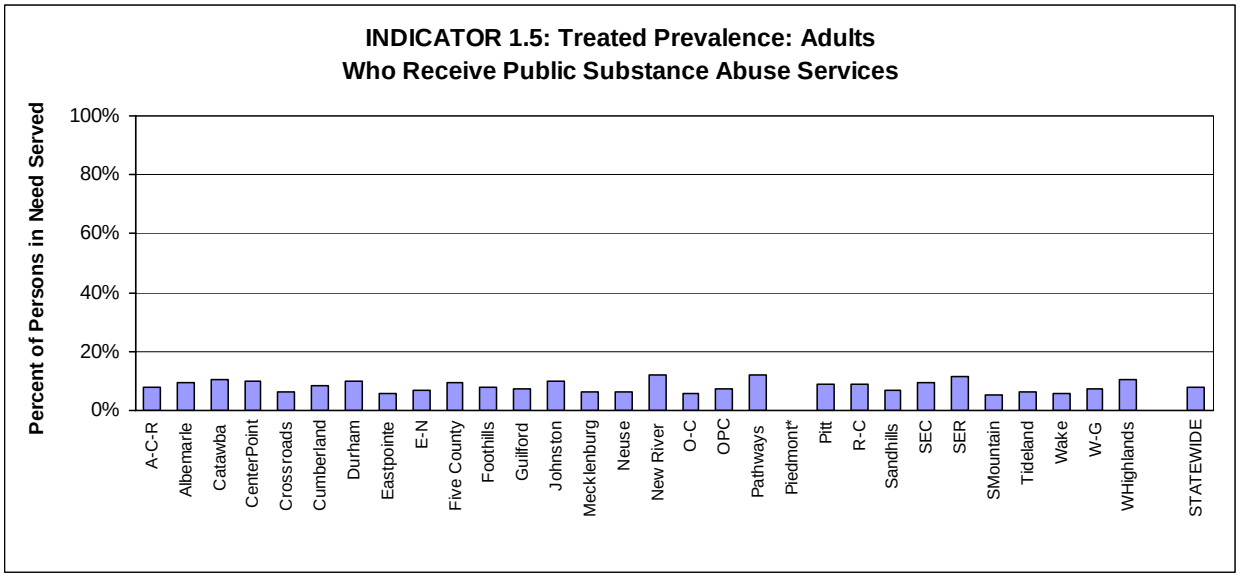
[10] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Estimates adjusted to North Carolina population.

[11] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[12] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

Indicator 1: Services to Persons in Need
1.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. April 1, 2006 - March 31, 2007; N=494,665 adults in need

Almost eighty out of every 1,000 adults (7.98%) in North Carolina experience a serious substance abuse problem in any given year.[13] Statewide, 39,882 adults (8% of those in need of services) received federal or state funded SA services through our community service system from April 2006 through March 2007.[14] The rate of adults who were served varied among LMEs from a low of 5% (Smoky Mountain) to a high of 12% (New River and Pathways).

Highlights: A total of 4 LMEs made progress from the second quarter to the fourth quarter, ranging increases of from 1% to 3% (Mecklenburg with the greatest change).

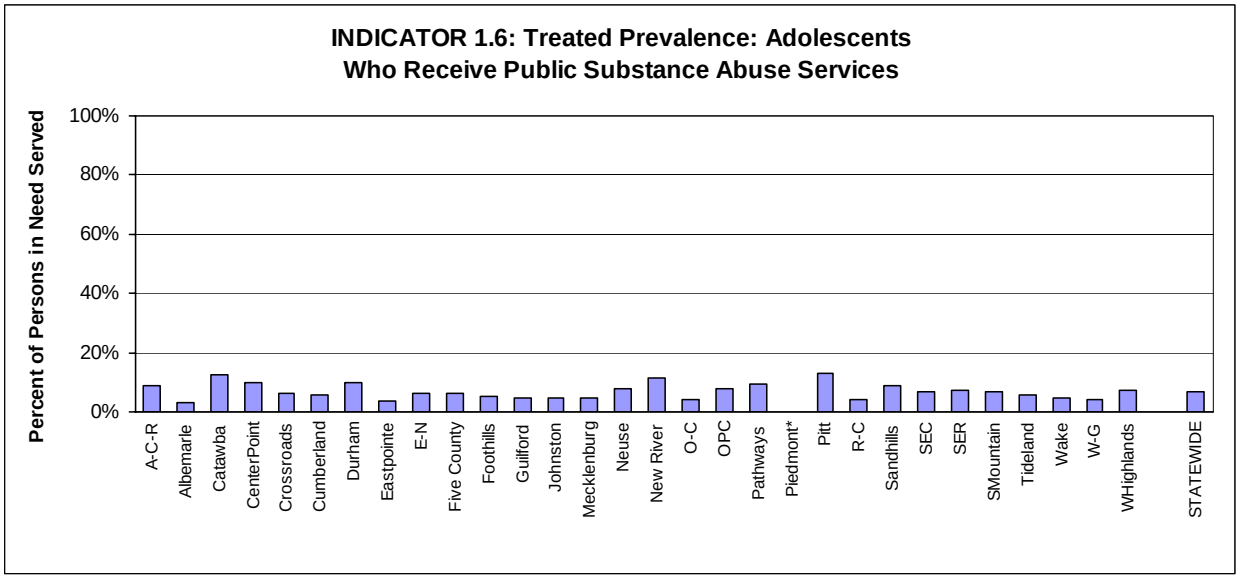
** Data on service claims for Piedmont are not available for this report.*

[13] *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates adjusted to North Carolina population.

[14] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 1: Services to Persons in Need
1.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. April 1, 2006 - March 31, 2007; N=47,673 adolescents in need

A little more than seventy out of every 1,000 adolescents (7.24% of those ages 12-17) in North Carolina experience a serious substance abuse problem in any given year.[15] Statewide, 3,202 adolescents (7% of those in need of services) received federal or state funded services through our community service system from April 2006 through March 2007.[16] The rate of targeted adolescents who were served varied among LMEs from a low of 3% (Albemarle) to a high of 13% (Pitt).

Highlights: A total of 6 LMEs increased services to adolescent substance abuse consumers by 1% from the second quarter to the fourth quarter.

** Data on service claims for Piedmont are not available for this report.*

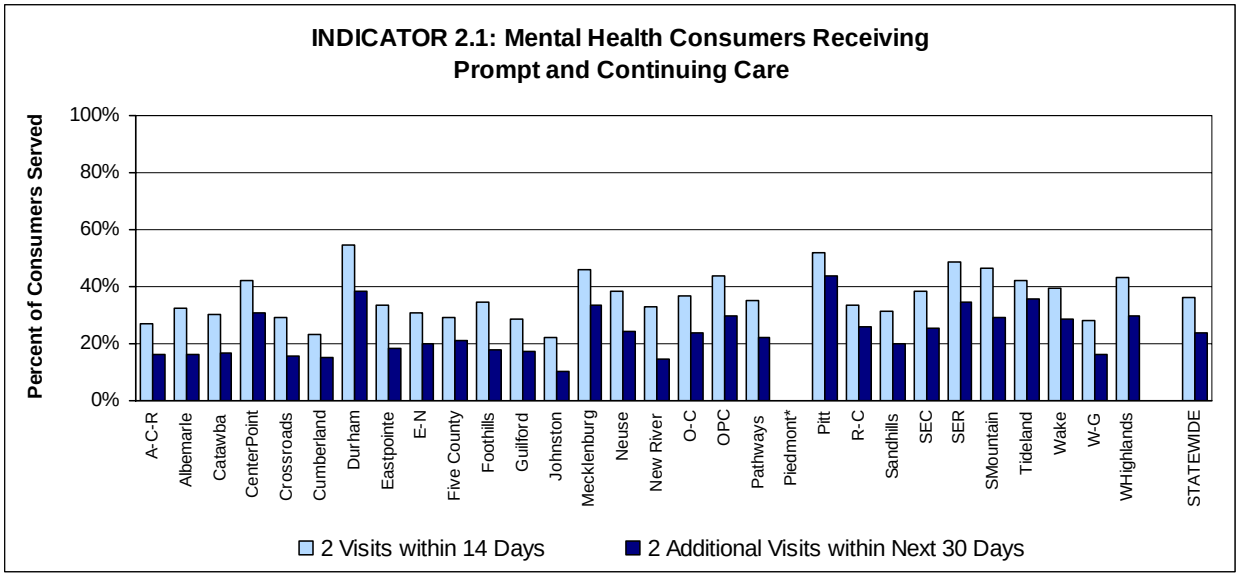
[15] *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health,* Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates adjusted to North Carolina population.

[16] The numbers served reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 2: Timely Initiation and Engagement in Service

2.1 Mental Health Services

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. October 1 - December 31, 2006 (first service received); N=43,055 consumers

Just over one-third (36%) of NC residents (all age groups) who receive mental health services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 22% (Johnston) to a high of 55% (Durham). Compared to the other disability groups, consumers with mental illness wait longer on average for initiation of care.

Approximately one-fourth (24%) of mental health consumers have an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 10% (Johnston) to a high of 44% (Pitt).

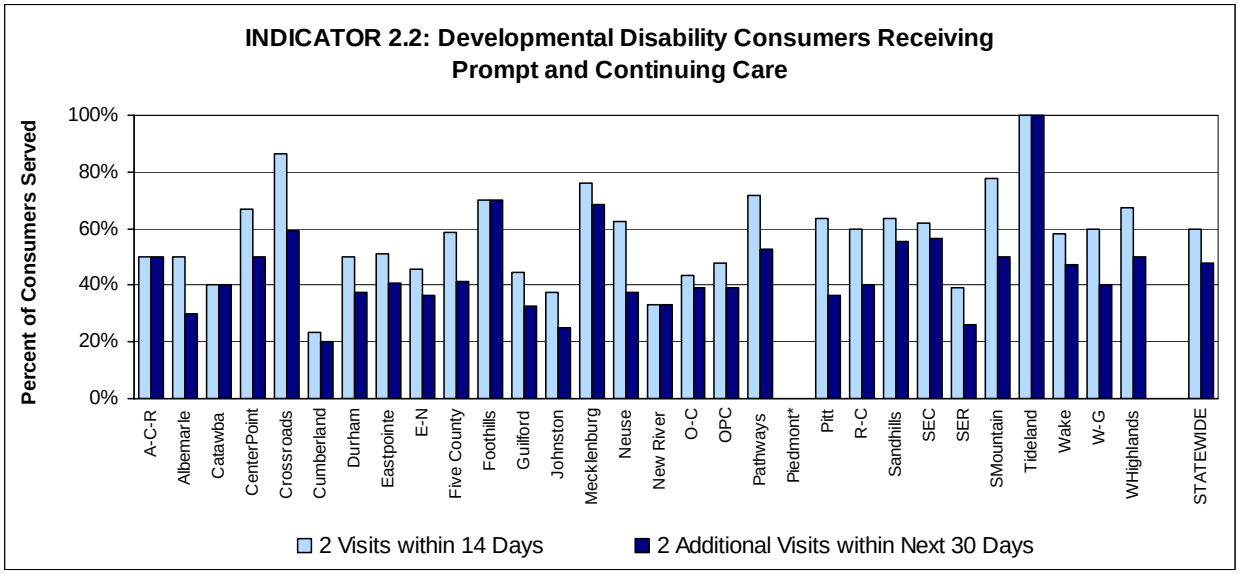
Highlights: For initiation, a total of 19 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 15% (Tideland with the greatest change). For engagement, a total of 22 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 20% (Tideland with the greatest change).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service

2.2 Developmental Disability Services

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. October 1 - December 31, 2006 (first service received); N=815 consumers

Sixty percent of NC residents (all age groups) who receive developmental disability services/supports have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 23% (Cumberland) to a high of 100% (Tideland).

Almost half (48%) of developmental disability consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 20% (Cumberland) to a high of 100% (Tideland).

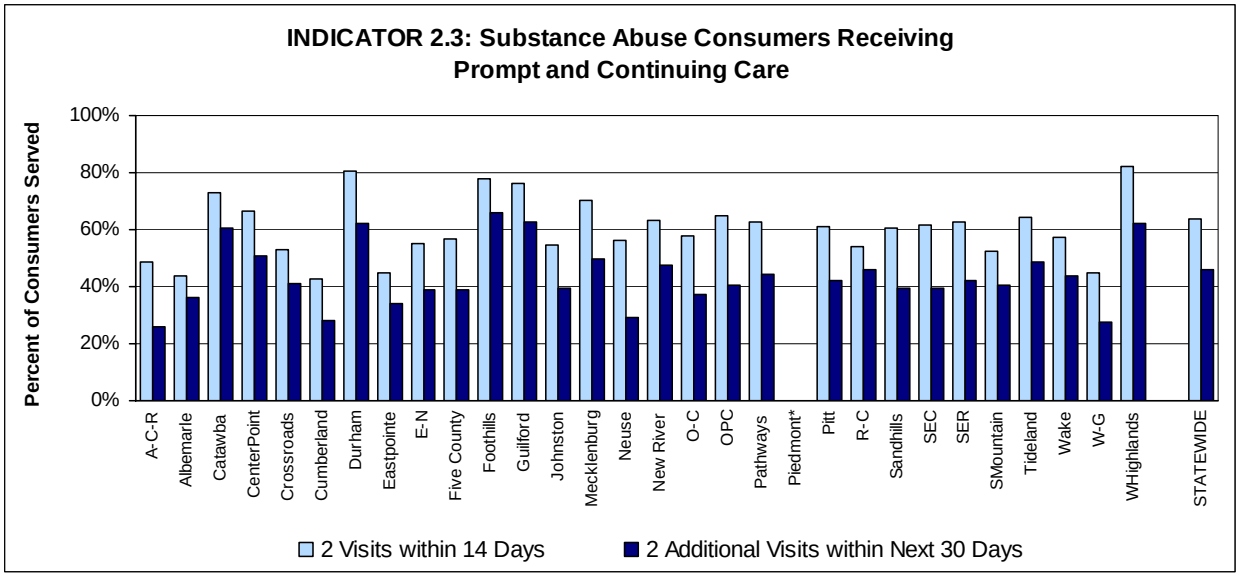
Highlights: For initiation, a total of 11 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 2% to 38% (Mecklenburg with the greatest change). For engagement, a total of 11 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 45% (Mecklenburg with the greatest change).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service

2.3 Substance Abuse Services

Rationale: National standards[17] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. October 1 - December 31, 2006 (first service received); N=4,227 consumers

Slightly under two-thirds (64%) of NC residents (all age groups) who receive substance abuse services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 43% (Cumberland) to a high of 82% (Western Highlands).

Less than half (46%) of substance abuse consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 28% (Wilson-Greene) to a high of 66% (Foothills).

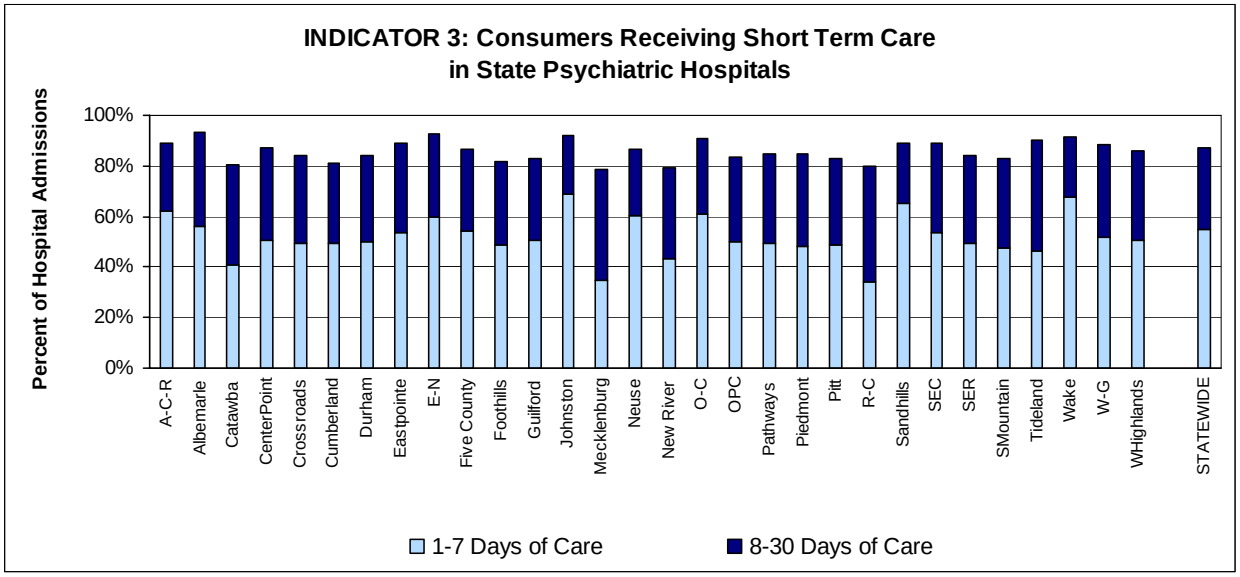
Highlights: For initiation, a total of 18 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 32% (Southeastern Center with the greatest change). For engagement, a total of 21 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 33% (Tideland with the greatest change).

** Data on service claims for Piedmont are not available for this report.*

[17] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for discharges during January 1 - June 30, 2007; N=8,479 discharges

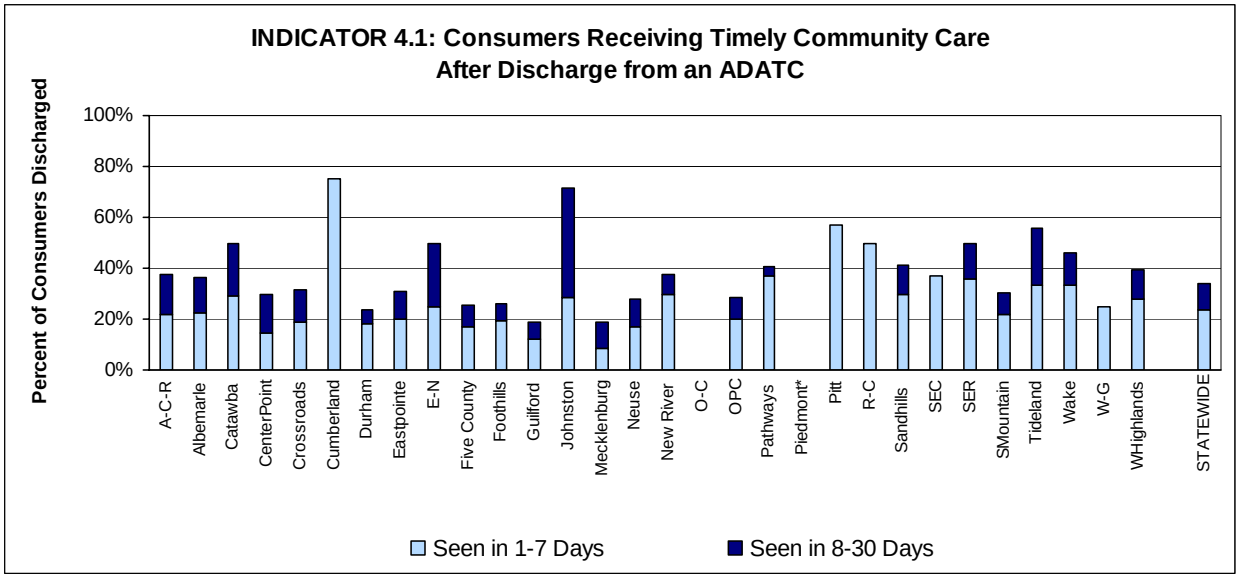
Of the statewide hospital discharges from January through June 2007, over half (55%) were hospitalized for 1-7 days (total number of statewide hospital stays for 1-7 days was 4,649) and 32% were hospitalized for 8-30 days (total number of statewide hospital stays for 8-30 days was 2,726). Lengths of stay of 1-7 days varied by LME from a high of 69% (Johnston) to a low of 34% (Roanoke-Chowan). Johnston and Wake had the lowest rates for lengths of stay of 8-30 days (with 23%) while Roanoke-Chowan had a high of 45%.

Highlights: For hospital stays of 1-7 days, a total of 17 LMEs made progress from the second quarter to the fourth quarter, ranging from a decrease of 1% to 11% (Southeastern Center with the greatest change). For hospital stays of 8-30 days, a total of 15 LMEs made progress from the second quarter to the fourth quarter, ranging from a decrease of 1% to 5% (Johnston and Southeastern Regional with the greatest change).

Indicator 4: Timely Follow-Up after Inpatient Care

4.1 ADATCs

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[18]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges October 1 - December 31, 2006); Medicaid and State Service Claims Data (for claims submitted October 1, 2006 - June 30, 2007); N=861 discharges

Statewide just under one-fourth (23%) of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 11% of NC consumers were seen within 8-30 days of discharge.

Onslow-Carteret did not have any discharges from an ADATC during the fourth quarter; however, among LMEs with discharges, the percent of consumers receiving follow-up care within 7 days varied from a low of 8% (Mecklenburg) to a high of 75% (Cumberland). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 18% (Mecklenburg) to a high of 75% (Cumberland).

Highlights: For consumers seen in 1-7 days, a total of 14 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 46% (Cumberland with the greatest change). For consumers seen in 8-30 days, a total of 15 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 34% (Johnston with the greatest change).

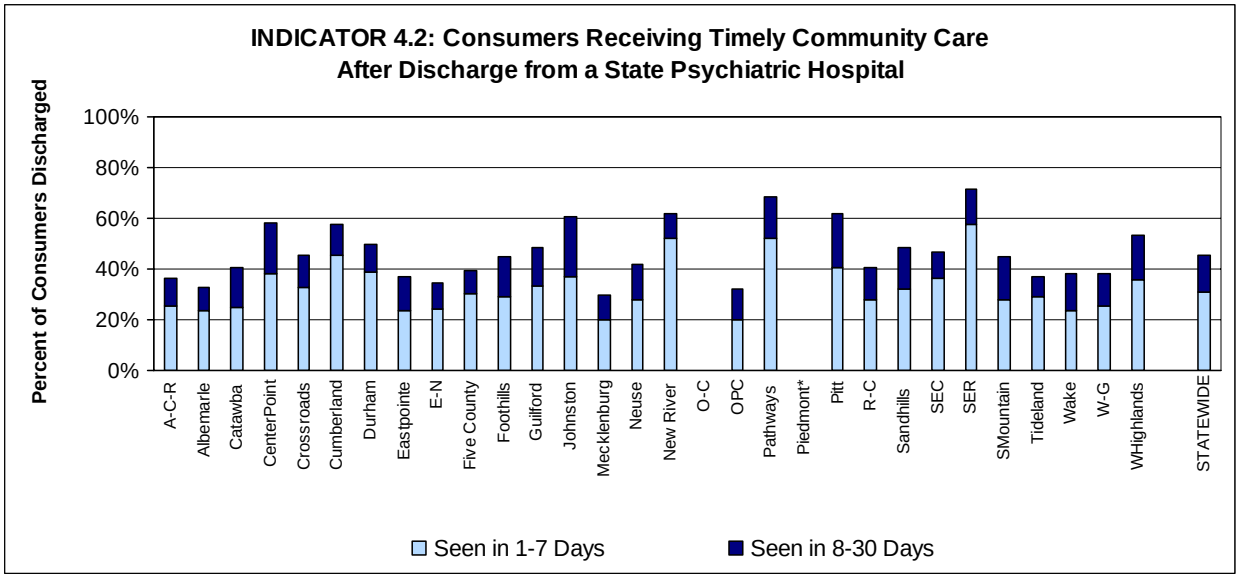
[18] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

** Data on service claims for Piedmont are not available for this report.*

Indicator 4: Timely Follow-Up after Inpatient Care

4.2 State Psychiatric Hospitals

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[19]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges October 1 - December 31, 2006); Medicaid and State Service Claims Data (for claims submitted October 1, 2006 - June 30, 2007); N=3,830 discharges

Statewide, just under one-third (31%) of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 14% of NC consumers were seen within 8-30 days of discharge.

Onslow-Carteret did not have any discharges from a state psychiatric hospital during the fourth quarter; however, among LMEs with discharges, the percent of consumers receiving follow-up care within 7 days varied from a low of 20% (Mecklenburg and OPC) to a high of 58% (Southeastern Regional). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 30% (Mecklenburg) to a high of 72% (Southeastern Regional).

Highlights: For consumers seen in 1-7 days, a total of 18 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 15% (CenterPoint with the greatest change). For consumers seen in 8-30 days, a total of 8 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 1% to 11% (Smoky Mountain with the greatest change).

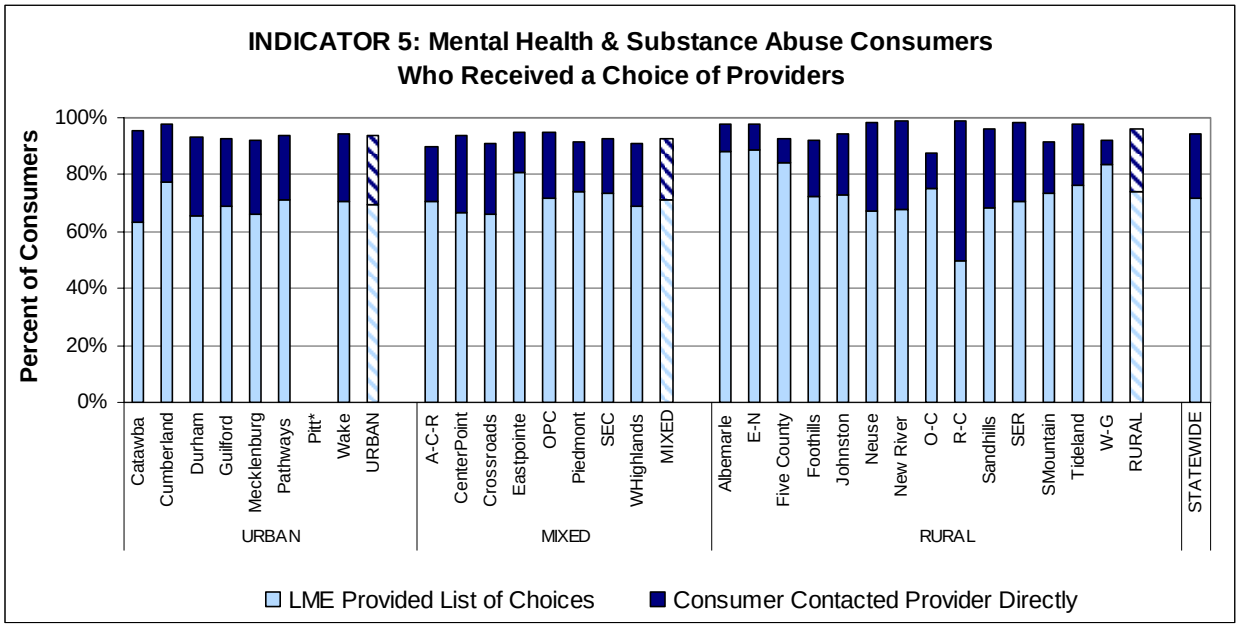
** Data on service claims for Piedmont are not available for this report.*

[19] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

Service Quality

Indicator 5: Consumer Choice of Service Providers

Rationale: A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. April 1 - June 30, 2007; N=17,262 Initial Interviews

Statewide, 72% of MH and SA consumers reported receiving options of places to receive services.[20] An additional 22% reported they contacted the provider directly. Among LMEs, the percent of consumers who were offered a list of options or who went directly to a provider varied from a low of 88% (Onslow-Carteret) to a high of 99% (New River and Roanoke-Chowan).

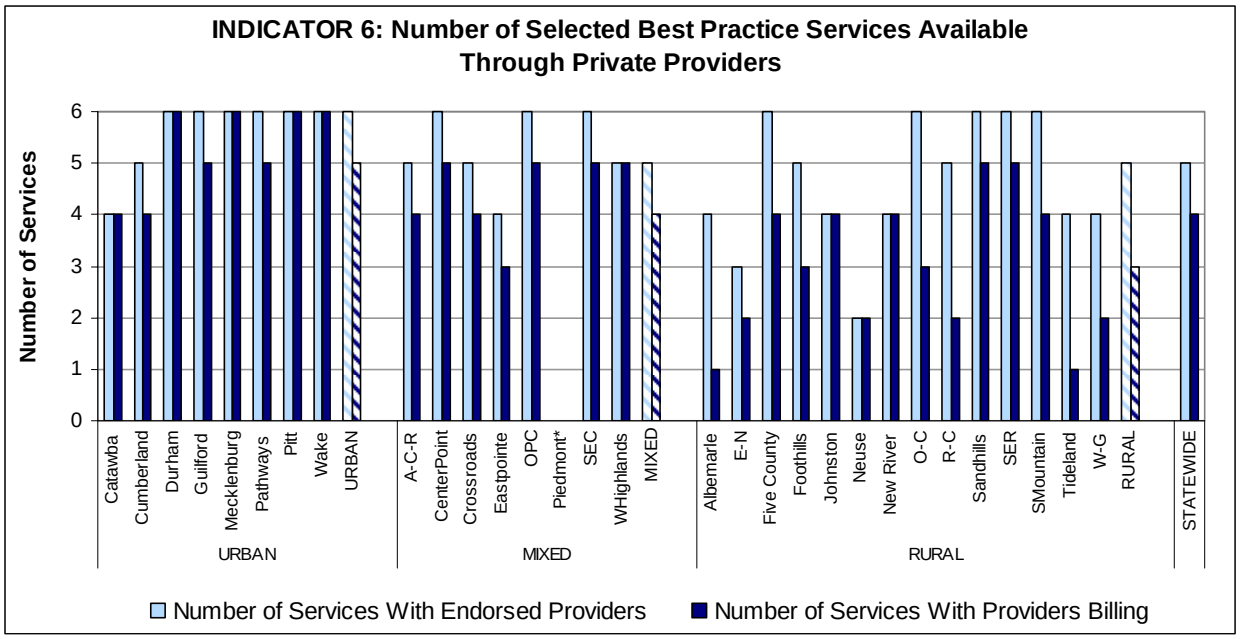
Highlights: A total of 15 LMEs made progress from the second quarter to the fourth quarter in providing consumers with options of places to receive services, increases ranged from 1% to 24% (Cumberland with the greatest change).

** Provider Choice Data for Pitt are reported under Neuse.*

[20] The question in the Initial NC-TOPPS Interview reads: "Did you receive a list of options, verbal or written, of places to receive services?" Response options include "Yes, I received a list," "No, I came here on my own," and "No, I did not receive a list." Appropriate NC-TOPPS questions for DD consumers are currently being developed.

Indicator 6: Use of Evidence-Based Service Models and Best Practices

Rationale: Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices and best practices in community service systems.



SOURCE: Medicaid Provider Endorsement Data and Medicaid Claims Data. April 1, 2006 - June 30, 2007; N=2,362 Endorsed Providers

North Carolina has endorsed over 2,300 private provider agencies (other than LMEs) across the state to offer six services that are based on best practice models:

- Multi-systemic therapy (MST)**
- Assertive community treatment team (ACTT)**
- Community support/community support team (CS/CST)
- Intensive in-home (IIH)
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment (SACOT).

All six services are endorsed in 14 LMEs, although only four LMEs (Durham, Mecklenburg, Pitt, and Wake) have agencies that are currently providing all of them. Eight LMEs have agencies currently providing five of these services and another eight LMEs have agencies providing four of these services.

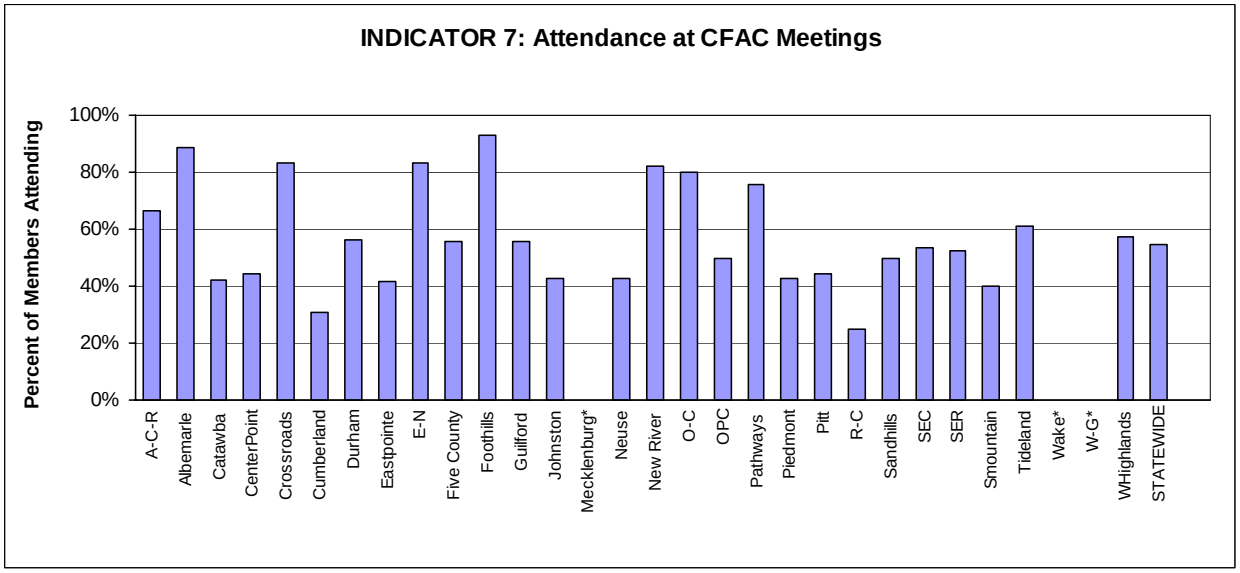
** Data on service claims for Piedmont are not available for this report.*

*** Multi-systemic therapy (MST) and assertive community treatment team (ACTT) are evidence-based practices.*

System Management

Indicator 7: Involvement of Consumers and Family Members in the Local System

Rationale: The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.



SOURCE: Local CFAC meeting minutes. April 1 - June 30, 2007

Local Consumer and Family Advisory Committees (CFACs) are composed of consumers and family members representing each of the MH/DD/SA disabilities. CFACs in all of the LMEs, except one (Roanoke-Chowan), met monthly during the quarter. Statewide, the expected membership ranges from 9 in Guilford to 30 in OPC. Across the state, an average of 55% of expected members attended scheduled meetings.[21] Roanoke-Chowan had the lowest average of expected attendance (25% of 12 potential members) and Foothills had the highest (93% of 14 potential members).

Highlights: A total of 14 LMEs made progress from the second quarter to the fourth quarter, ranging from increases of 3% to 39% (Foothills with the greatest change).

* *Edgecombe-Nash and Wilson-Greene share one CFAC and are reported under Edgecombe-Nash. Mecklenburg and Wake have not set an expected number of members. Mecklenburg averaged 11 members attending and Wake averaged 7 members attending.*

[21] Numbers in attendance include only appointed members.

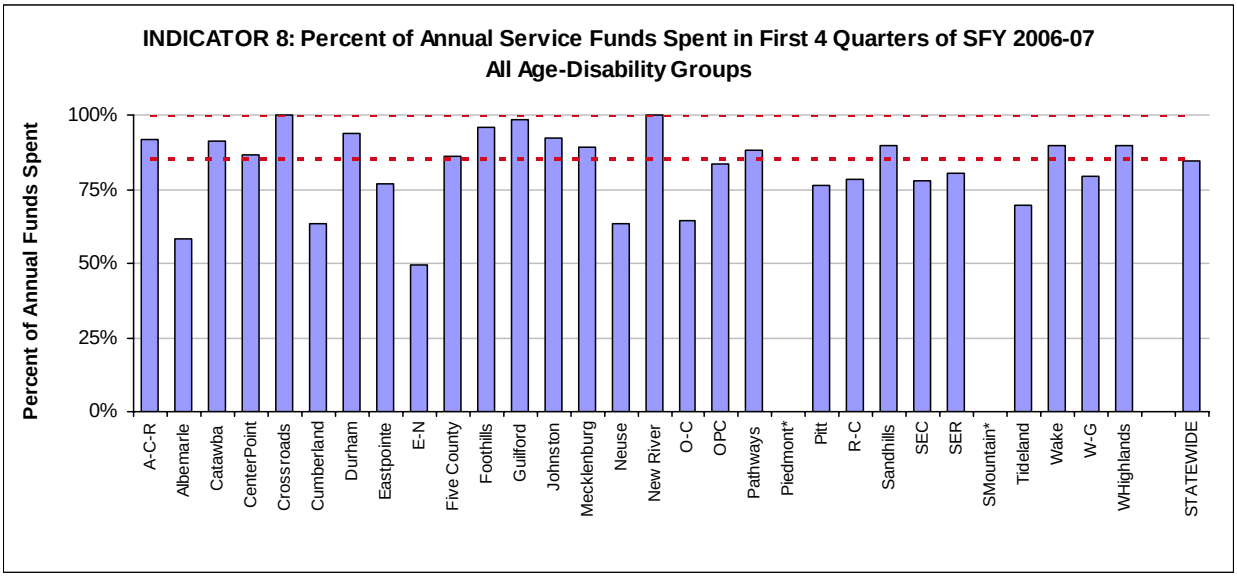
Indicator 8: Effective Management of Service Funds

All Disability Groups

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

LME use of state and federal (non-Medicaid) funds can be affected by several factors, including[22]:

- the availability and use of local funds
- the proportion of the local population receiving Medicaid services
- local claims submission practices



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - June 30, 2007;
Total Budgeted UCR Funds=$244,579,399

Expenditures are expected to be between 85% and 100% at the end of the fourth quarter (indicated by the dotted red lines). Across all disabilities, LMEs spent an average of 85% of their LME-managed service funds during SFY 2006-07.[23] Expenditures vary from a low of 50% (Edgecombe-Nash) to a high of 100% (Crossroads and New River). The expenditure of funds by age-disability group is not presented in this report due to the movement of allocated funds. In the fourth quarter, the Division approved some LME requests for transfer of funds across age-disability groups as well as some LME requests to transfer funds from UCR to non-UCR accounts to support the development of provider capacity and local infrastructure.

** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

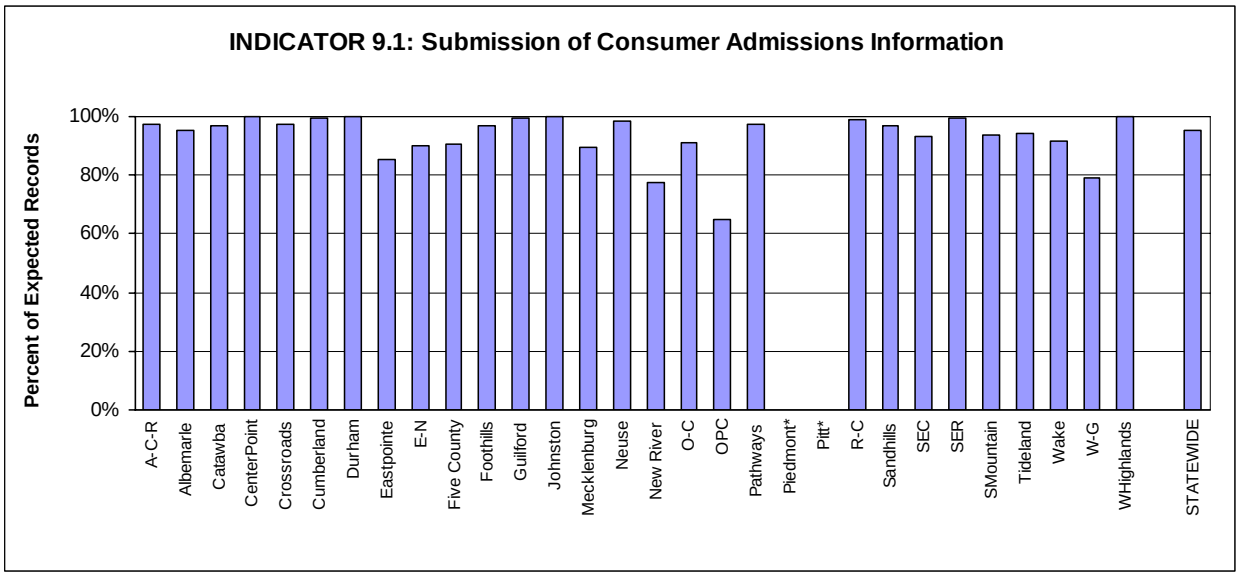
[22] In SFY 2006-07 LMEs are allowed to shift up to 15% of State-allocated funds between age-disability groups.

[23] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 9: Effective Management of Information

9.1 Consumer Admissions

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: Consumer Data Warehouse Data. January - June 2007; State Service Claims Data (for claims submitted January - June 2007 for services provided January - March 2007). N=28,406 records received

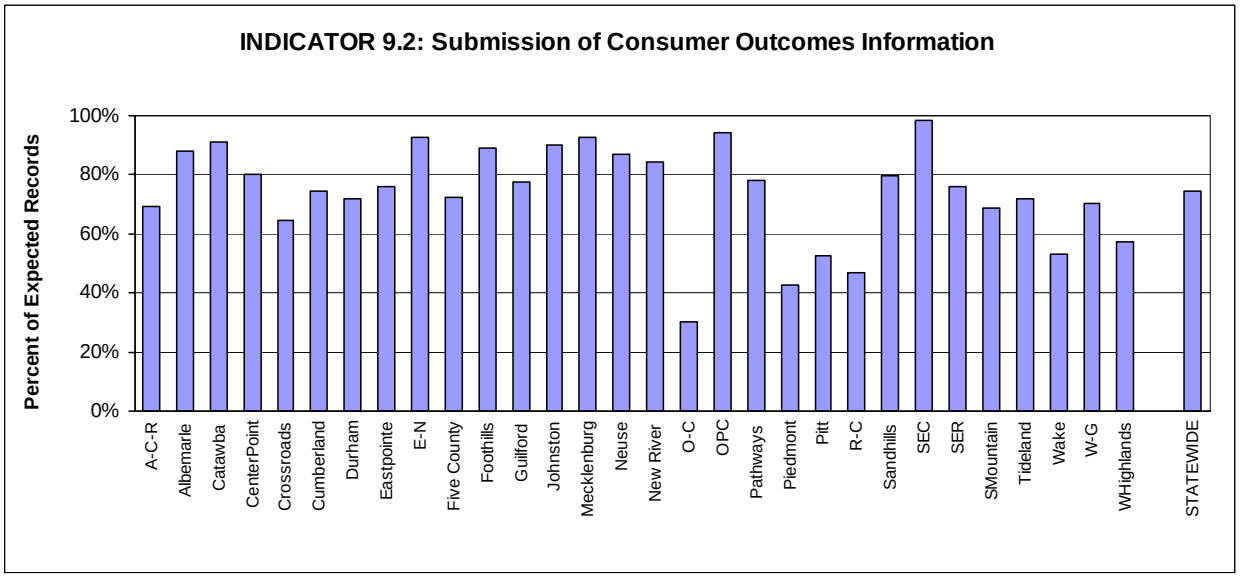
Statewide, identification and demographic information was submitted on 95% of consumers that received a State-funded service during the prior quarter (January 1 - March 31, 2007). Submissions varied among LMEs from a low of 65% (OPC) to a high of 100% by five LMEs (CenterPoint, Cumberland, Durham, Johnston, and Western Highlands).

Highlights: A total of 15 LMEs made progress on submission of consumer admission information from the second quarter to the fourth quarter, ranging from increases of 1% to 15% (Pathways with the greatest change).

** Admissions data for Pitt are reported under Neuse. Piedmont data are not available for this report.*

Indicator 9: Effective Management of Information
9.2 Consumer Outcomes

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data (for Initial Interviews October - December 2006). Updates received October 1, 2006 - June 30, 2007; N=11,806 expected updates

Statewide, NC-TOPPS Update Interviews (due after 90 days of service) were submitted for approximately three-fourths (74%) of MH/SA consumers who had an Initial Interview between October and December 2006. The percent of expected Update Interviews submitted varied among LMEs from a low of 30% (Onslow-Carteret) to a high of 99% (Southeastern Center).

Highlights: A total of 17 LMEs made progress on submission of consumer outcome information from the second quarter to the fourth quarter, ranging from increases of 3% to 49% (Edgecombe-Nash with the greatest change).

The MH/DD/SAS Community Systems Progress Indicators Report and the Report Appendices are published four times a year. Both are available on the Division's website:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/

Questions and feedback should be directed to:
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(919/733-0696)